EDS TPL CHANGE REQUEST FORM

*Provider Name:_____ *Provider NPI:_____

*Person making request:_____ *Contact # of Requestor:_____

*Recipient Name:_____ *Medicaid ID Number:_____

***Fully explain changes requested:**

***If coverage does not exist attach a denial EOB or complete website print out.**

***New policy information**:

*Insurance company:	*Insurance address:
*Insurance phone number:	*Insurance city,state,zip:
*Policy holder name:	*Policy number:
*Employer:	*Group number:
*Effective start date:	*End date:

***Coverage type:** Dental___ Major Medical___ Outpatient/Inpatient___ Pharmacy___ MCR supplement___ Vision___

Please attach print out from OI website

FOR INTERNAL USE ONLY:

*Indicates mandatory fields

*Please submit requests to: TPL via fax at 1-802-878-3440 or provider offices can submit via mail to: EDS, ATTN: TPL, PO Box 888, Williston, VT 05495